UNIVERSITY SQUARE DENTAL ASSOCIATES
Kristen Leong, DMD LLC
3901 MARKET STREET • BOX 1936 • PHILADELPHIA, PA 19104
TELEPHONE: (215)-662-1030 • FAX: (215)-662-1015
EMAIL: UniversitySquareDentalAssc1@gmail.com
universitysquaredental.com/

EXPLANATION OF DENTAL BENEFITS AND FINANCIAL POLICY

We will be glad to help you obtain the appropriate benefit from your insurance carrier and bill your carrier as a courtesy to you. You are responsible for the co-payment, which is the difference between our fee and the amount paid by your insurance carrier. (Even if you have double coverage, there may still be a portion that will be your responsibility).Please remember that dental insurance benefits are based on a contract between you and the insurance carrier, and you are ultimately responsible for your account. If there is any change in your insurance coverage, personal information, or medical history, please inform our office immediately. Our qualified staff will be glad to answer all your payment and insurance questions.

Payment is required for all dental care at the time of service. If your account is referred for collected, you will be responsible for collection costs: in the amount of 30% of the outstanding balance, together with court costs and reasonable attorney's fees. Visa, MasterCard, and Discover are accepted for your convenience. **We do not accept personal or business checks.**

Your appointment time will be reserved exclusively for you. Please note your appointment time carefully. Courtesy text messages and emails may be sent, however it is your responsibility to keep your appointments.

A fee of $100 will be charged for a missed or rescheduled appointment without 24 hours advance notice. _____ (please initial here)

We understand that certain situations can arise, however, our computerized scheduler will automatically charge your account for any appointment change without sufficient notice. Please avoid this unpleasant situation for both of us by simply calling 24 hours in advance if you must reschedule.

Although the office may assist you with reminder letters or telephone calls, it is your responsibility to follow the recommended treatment and maintenance program.

The above information is intended to provide clarification and prevent any future misunderstanding. We welcome you to our office and assure you that we will provide you with the best care possible.

I have read the above and understand the financial policy of University Square Dental Associates.

Print: _____

Signature: _____ Date: _____